

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036464

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9575

FILED OCT 11 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON1. PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. LouisLength of stay in lb
60 Yearsc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION 112 North Newstead Ave.Inside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTYc. CITY
OR
TOWN St. Louis,Inside Limits
Yes ☒ No ☐d. STREET
ADDRESS (If outside, give location)
112 North NewsteadReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Bernard

William

MAGINN

4. DATE
OF
DEATH

Month

Day

Year

October 5, 1962

5. SEX
Male6. COLOR OR RACE
Caucasian7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐8. DATE OF BIRTH
3-23-869. AGE (last birthday)
76IF UNDER 1 YEAR
Months Days Hours Min.IF UNDER 24 HR
Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)
Retired10b. KIND OF BUSINESS OR INDUSTRY
City of St. Louis11. BIRTHPLACE (City and state or country)
Fort Bayard, N. Mex.12. CITIZEN OF WHAT COUNTRY
U.S.

13a. FATHER'S NAME

Bernard W. Maginn

13b. MOTHER'S MAIDEN NAME

Delia D. Devaney

14. NAME OF HUSBAND OR WIFE

Single

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
YES WW I

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Leo Maginn, 4931 Laclede

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY Hour a.m. Month, Day, Year p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Oct 7 61 to Oct 4 62 and last saw her alive on Oct 1 62
Death occurred at His home 1:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Ink or type)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Arthur J. Donnelly 3840 Lindell Blvd.

OCT 6 1962

Karl Smith, M.D.

Mogin

Dr Martin Green
506 Olive St
St Paul 30 Ma

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Francis Williamson

Licensed Embalmer No. 3565

P. O. Address 3840 Lindell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.